

Proposed SNF QRP New and Modified Items

Effective Date: October 1, 2020

ADMISSION (Start of SNF Stay)

Section A Identification Information

A1005. Ethnicity

Are you Hispanic, Latino/a, or Spanish origin?



Check all that apply

A. No, not of Hispanic, Latino/a, or Spanish origin

B. Yes, Mexican, Mexican American, Chicano/a

C. Yes, Puerto Rican

D. Yes, Cuban

E. Yes, Another Hispanic, Latino, or Spanish origin

X. Resident unable to respond

A1010. Race

What is your race?



Check all that apply

A. White

B. Black or African American

C. American Indian or Alaska Native

D. Asian Indian

E. Chinese

F. Filipino

G. Japanese

H. Korean

I. Vietnamese

J. Other Asian

K. Native Hawaiian

L. Guamanian or Chamorro

M. Samoan

N. Other Pacific Islander

X. Resident unable to respond

A1110. Language

Enter Code

A. What is your preferred language?**B. Do you need or want an interpreter to communicate with a doctor or health care staff?**

0. No

1. Yes

9. Unable to determine

A1250. Transportation

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

**Check all that apply****A. Yes**, it has kept me from medical appointments or from getting my medications**B. Yes**, it has kept me from non-medical meetings, appointments, work, or from getting things that I need**C. No****D. Resident unable to respond****A1805. Entered From**

Enter Code

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)02. **Nursing home** (long-term care facility)03. **Skilled Nursing Facility** (SNF, swing beds)04. **Short-term General Hospital** (acute hospital, IPPS)05. **Long-Term Care Hospital** (LTCH)06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)08. **Intermediate Care Facility** (ID/DD facility)09. **Hospice** (home/non-institutional)10. **Hospice** (institutional facility)11. **Critical Access Hospital** (CAH)12. **Home under care of organized home health service organization**99. **Not Listed**

Section B	Hearing, Speech, and Vision
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B1300. Health Literacy
 How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Enter Code <input type="text"/>	0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 5. Resident unable to respond
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Section D	Mood
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D0150. Resident Mood Interview (PHQ-2 to 9)

Say to resident: "Over the last 2 weeks, have you been bothered by any of the following problems?"
 If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
 If yes in column 1, then ask the resident: "About **how often** have you been bothered by this?"
 Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence	2. Symptom Frequency	1. Symptom Presence	2. Symptom Frequency
0. No (enter 0 in column 2) 1. Yes (enter 0-3 in column 2) 9. No response (leave column 2 blank)	0. Never or 1 day 1. 2-6 days (several days) 2. 7-11 days (half or more of the days) 3. 12-14 days (nearly every day)		
		↓ Enter Scores in Boxes ↓	
A. Little interest or pleasure in doing things		<input type="text"/>	<input type="text"/>
B. Feeling down, depressed, or hopeless		<input type="text"/>	<input type="text"/>
If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview and SKIP to next section.			
C. Trouble falling or staying asleep, or sleeping too much		<input type="text"/>	<input type="text"/>
D. Feeling tired or having little energy		<input type="text"/>	<input type="text"/>
E. Poor appetite or overeating		<input type="text"/>	<input type="text"/>
F. Feeling bad about yourself – or that you are a failure or have let yourself or your family down		<input type="text"/>	<input type="text"/>
G. Trouble concentrating on things, such as reading the newspaper or watching television		<input type="text"/>	<input type="text"/>
H. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual		<input type="text"/>	<input type="text"/>
I. Thoughts that you would be better off dead, or of hurting yourself in some way		<input type="text"/>	<input type="text"/>

D0160. Total Severity Score

Enter Score

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27.

Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items)

D0700. Social Isolation

How often do you feel lonely or isolated from those around you?

Enter Code

- 0. **Never**
- 1. **Rarely**
- 2. **Sometimes**
- 3. **Often**
- 4. **Always**
- 9. **Resident unable to respond**

Section J**Health Conditions****J0510. Pain Effect on Sleep**

Enter Code

Ask resident: "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?"

- 1. **Rarely or not at all**
- 2. **Occasionally**
- 3. **Frequently**
- 4. **Almost constantly**
- 9. **Unable to answer**

J0520. Pain Interference with Therapy Activities

Enter Code

Ask resident: "Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?"

- 0. **Does not apply – I have not received rehabilitation therapy in the past 5 days**
- 1. **Rarely or not at all**
- 2. **Occasionally**
- 3. **Frequently**
- 4. **Almost constantly**
- 9. **Unable to answer**

J0530. Pain Interference with Day-to-Day Activities

Enter Code

Ask resident: "Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"

- 1. **Rarely or not at all**
- 2. **Occasionally**
- 3. **Frequently**
- 4. **Almost constantly**
- 9. **Unable to answer**

Section K	Swallowing/Nutritional Status
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K0520. Nutritional Approaches	
Check all of the following nutritional approaches that were performed on admission	
	On Admission
	Check all that apply ↓
A. Parenteral/IV feeding	<input type="checkbox"/>
B. Feeding tube (e.g., nasogastric or abdominal (PEG))	<input type="checkbox"/>
C. Mechanically altered diet – require change in texture of food or liquids (e.g., pureed food, thickened liquids)	<input type="checkbox"/>
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	<input type="checkbox"/>
Z. None of the above	<input type="checkbox"/>

Section N	Medications
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N0415. High-Risk Drug Classes: Use and Indication		
1. Is taking Check if the resident is taking any medications in the following drug classes by pharmacological classification, not how it is used 2. Indication noted If Column 1 is checked, check if there is an indication noted for all medications in the drug class	1. Is taking	2. Indication noted
	Check all that apply ↓	Check all that apply ↓
A. Antipsychotic	<input type="checkbox"/>	<input type="checkbox"/>
B. Antianxiety	<input type="checkbox"/>	<input type="checkbox"/>
C. Antidepressant	<input type="checkbox"/>	<input type="checkbox"/>
D. Hypnotic	<input type="checkbox"/>	<input type="checkbox"/>
E. Anticoagulant	<input type="checkbox"/>	<input type="checkbox"/>
F. Antibiotic	<input type="checkbox"/>	<input type="checkbox"/>
G. Diuretic	<input type="checkbox"/>	<input type="checkbox"/>
H. Opioid	<input type="checkbox"/>	<input type="checkbox"/>
I. Antiplatelet	<input type="checkbox"/>	<input type="checkbox"/>
J. Hypoglycemic (including insulin)	<input type="checkbox"/>	<input type="checkbox"/>

Section O	Special Treatments, Procedures, and Programs
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O0110. Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that were performed on admission	On Admission Check all that apply ↓
Cancer Treatments	
A1. Chemotherapy	<input type="checkbox"/>
A2. IV	<input type="checkbox"/>
A3. Oral	<input type="checkbox"/>
A10. Other	<input type="checkbox"/>
B1. Radiation	<input type="checkbox"/>
Respiratory Therapies	
C1. Oxygen Therapy	<input type="checkbox"/>
C2. Continuous	<input type="checkbox"/>
C3. Intermittent	<input type="checkbox"/>
C4. High-concentration	<input type="checkbox"/>
D1. Suctioning	<input type="checkbox"/>
D2. Scheduled	<input type="checkbox"/>
D3. As Needed	<input type="checkbox"/>
E1. Tracheostomy care	<input type="checkbox"/>
F1. Invasive Mechanical Ventilator (ventilator or respirator)	<input type="checkbox"/>
G1. Non-Invasive Mechanical Ventilator	<input type="checkbox"/>
G2. BiPAP	<input type="checkbox"/>
G3. CPAP	<input type="checkbox"/>
Other	
H1. IV Medications	<input type="checkbox"/>
H2. Vasoactive medications	<input type="checkbox"/>
H3. Antibiotics	<input type="checkbox"/>
H4. Anticoagulation	<input type="checkbox"/>
H10. Other	<input type="checkbox"/>
I1. Transfusions	<input type="checkbox"/>

O0110. Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that were performed on admission	On Admission Check all that apply ↓
J1. Dialysis	<input type="checkbox"/>
J2. Hemodialysis	<input type="checkbox"/>
J3. Peritoneal dialysis	<input type="checkbox"/>
O1. IV Access	<input type="checkbox"/>
O2. Peripheral	<input type="checkbox"/>
O3. Midline	<input type="checkbox"/>
O4. Central (e.g., PICC, tunneled, port)	<input type="checkbox"/>
None of the Above	
Z1. None of the above	<input type="checkbox"/>

PLANNED DISCHARGE (End of SNF Stay)

A0310G =1

Section A

Identification Information

A1110. Language

Enter Code

A. What is your preferred language?

B. Do you need or want an interpreter to communicate with a doctor or health care staff?

0. No

1. Yes

9. Unable to determine

A1250. Transportation

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?



Check all that apply

A. Yes, it has kept me from medical appointments or from getting my medications

B. Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need

C. No

D. Resident unable to respond

A2105. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)

02. **Nursing home** (long-term care facility)

03. **Skilled Nursing Facility** (SNF, swing beds)

04. **Short-term General Hospital** (acute hospital, IPPS)

05. **Long-Term Care Hospital** (LTCH)

06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)

07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)

08. **Intermediate Care Facility** (ID/DD facility)

09. **Hospice** (home/non-institutional)

10. **Hospice** (institutional facility)

11. **Critical Access Hospital** (CAH)

12. **Home under care of organized home health service organization**

99. **Not Listed**

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider?

Enter Code

0. **No** – Current reconciled medication list not provided to the subsequent provider
 1. **Yes** – Current reconciled medication list provided to the subsequent provider

A2122. Provision of Current Reconciled Medication List to Resident at Discharge

At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver?

Enter Code

0. **No** – Current reconciled medication list not provided to the resident, family and/or caregiver
 1. **Yes** – Current reconciled medication list provided to the resident, family and/or caregiver

A2123. Route of Current Reconciled Medication List Transmission

Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider and/or resident/family/caregiver.

Route of Transmission	1. To subsequent provider	2. To resident/family/ caregiver
	↓ Check all that apply ↓	
A. Electronic Health Record	<input type="checkbox"/>	<input type="checkbox"/>
B. Health Information Exchange Organization	<input type="checkbox"/>	<input type="checkbox"/>
C. Verbal (e.g., in-person, telephone, video conferencing)	<input type="checkbox"/>	<input type="checkbox"/>
D. Paper-based (e.g., fax, copies, printouts)	<input type="checkbox"/>	<input type="checkbox"/>
E. Other Methods (e.g., texting, email, CDs)	<input type="checkbox"/>	<input type="checkbox"/>

Section B	Hearing, Speech, and Vision
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B1300. Health Literacy	
How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?	
Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<ul style="list-style-type: none"> 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 9. Resident unable to respond

Section C	Cognitive Patterns
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C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?	
Attempt to conduct interview with all residents	

Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<ul style="list-style-type: none"> 0. No (resident is rarely/never understood) → <i>Skip to XXXX</i> 1. Yes → <i>Continue to C0200, Repetition of Three Words</i>
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Brief Interview for Mental Status (BIMS)	
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C0200. Repetition of Three Words	
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Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<p>Ask resident: <i>"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words."</i></p> <p>Number of words repeated after first attempt</p> <ul style="list-style-type: none"> 0. None 1. One 2. Two 3. Three <p>After the resident's first attempt, repeat the words using cues (<i>"sock, something to wear; blue, a color; bed, a piece of furniture"</i>). You may repeat the words up to two more times.</p>
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C0300. Temporal Orientation (orientation to year, month, and day)	
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Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<p>Ask resident: <i>"Please tell me what year it is right now."</i></p> <p>A. Able to report correct year</p> <ul style="list-style-type: none"> 0. Missed by > 5 years or no answer 1. Missed by 2-5 years 2. Missed by 1 year 3. Correct
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Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<p>Ask resident: <i>"What month are we in right now?"</i></p> <p>B. Able to report correct month</p> <ul style="list-style-type: none"> 0. Missed by > 1 month or no answer 1. Missed by 6 days to 1 month 2. Accurate within 5 days
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Enter Code <input type="checkbox"/>	Ask resident: <i>"What day of the week is today?"</i> C. Able to report correct day of the week 0. Incorrect or no answer 1. Correct
C0400. Recall	
Enter Code <input type="checkbox"/>	Ask resident: <i>"Let's go back to an earlier question. What were those three words that I asked you to repeat?"</i> If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word. A. Able to recall "sock" 0. No - could not recall 1. Yes, after cueing ("something to wear") 2. Yes, no cue required
Enter Code <input type="checkbox"/>	B. Able to recall "blue" 0. No - could not recall 1. Yes, after cueing ("a color") 2. Yes, no cue required
Enter Code <input type="checkbox"/>	C. Able to recall "bed" 0. No - could not recall 1. Yes, after cueing ("a piece of furniture") 2. Yes, no cue required
C0500. BIMS Summary Score	
Enter Score <input type="text"/> <input type="text"/>	Add scores for questions C0200-C0400 and fill in total score (00-15) Enter 99 if the resident was unable to complete the interview

C1310. Signs and Symptoms of Delirium (from CAM©)	
Code after completing Brief Interview for Mental Status and reviewing medical record.	
A. Acute Onset Mental Status Change	
Enter Code <input type="checkbox"/>	Is there evidence of an acute change in mental status from the resident's baseline? 0. No 1. Yes
Coding: 0. Behavior not present 1. Behavior continuously present, does not fluctuate 2. Behavior present, fluctuates (comes and goes, changes in severity)	↓
	Enter Code in Boxes
	<input type="checkbox"/> B. Inattention – Did the resident have difficulty focusing attention, for example being easily distractible or having difficulty keeping track of what was being said?
	<input type="checkbox"/> C. Disorganized thinking – Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
<input type="checkbox"/> D. Altered level of consciousness – Did the resident have altered level of consciousness as indicated by any of the following criteria? <ul style="list-style-type: none"> • vigilant – startled easily to any sound or touch • lethargic – repeatedly dozed off when being asked questions, but responded to voice or touch • stuporous – very difficult to arouse and keep aroused for the interview • comatose – could not be aroused 	

Section D	Mood
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D0150. Resident Mood Interview (PHQ-2 to 9)

Say to resident: "Over the last 2 weeks, have you been bothered by any of the following problems?"

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.

If yes in column 1, then ask the resident: "About **how often** have you been bothered by this?"

Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence	2. Symptom Frequency	1. Symptom Presence	2. Symptom Frequency
0. No (enter 0 in column 2)	0. Never or 1 day	↓ Enter Scores in Boxes ↓	↓ Enter Scores in Boxes ↓
1. Yes (enter 0-3 in column 2)	1. 2-6 days (several days)		
9. No response (leave column 2 blank)	2. 7-11 days (half or more of the days)		
	3. 12-14 days (nearly every day)		
A. Little interest or pleasure in doing things		<input type="checkbox"/>	<input type="checkbox"/>
B. Feeling down, depressed, or hopeless		<input type="checkbox"/>	<input type="checkbox"/>
If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview and SKIP to next section.			
C. Trouble falling or staying asleep, or sleeping too much		<input type="checkbox"/>	<input type="checkbox"/>
D. Feeling tired or having little energy		<input type="checkbox"/>	<input type="checkbox"/>
E. Poor appetite or overeating		<input type="checkbox"/>	<input type="checkbox"/>
F. Feeling bad about yourself – or that you are a failure or have let yourself or your family down		<input type="checkbox"/>	<input type="checkbox"/>
G. Trouble concentrating on things, such as reading the newspaper or watching television		<input type="checkbox"/>	<input type="checkbox"/>
H. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual		<input type="checkbox"/>	<input type="checkbox"/>
I. Thoughts that you would be better off dead, or of hurting yourself in some way		<input type="checkbox"/>	<input type="checkbox"/>
D0160. Total Severity Score			
Enter Score	Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27.		
<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items)		

D0700. Social Isolation

How often do you feel lonely or isolated from those around you?

Enter Code

- 0. **Never**
- 1. **Rarely**
- 2. **Sometimes**
- 3. **Often**
- 4. **Always**
- 9. **Resident unable to respond**

Section J**Health Conditions****J0510. Pain Effect on Sleep**

Enter Code

Ask resident: "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?"

- 1. **Rarely or not at all**
- 2. **Occasionally**
- 3. **Frequently**
- 4. **Almost constantly**
- 9. **Unable to answer**

J0520. Pain Interference with Therapy Activities

Enter Code

Ask resident: "Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?"

- 0. **Does not apply – I have not received rehabilitation therapy in the past 5 days**
- 1. **Rarely or not at all**
- 2. **Occasionally**
- 3. **Frequently**
- 4. **Almost constantly**
- 9. **Unable to answer**

J0530. Pain Interference with Day-to-Day Activities

Enter Code

Ask resident: "Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"

- 1. **Rarely or not at all**
- 2. **Occasionally**
- 3. **Frequently**
- 4. **Almost constantly**
- 9. **Unable to answer**

Section K	Swallowing/Nutritional Status
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K0520. Nutritional Approaches		
While a Resident Performed <i>while a resident</i> of this facility and within the <i>last 7 days</i> At Discharge	1. While a Resident	2. At Discharge
	↓ Check all that apply ↓	
A. Parenteral/IV feeding	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeding tube (e.g., nasogastric or abdominal (PEG))	<input type="checkbox"/>	<input type="checkbox"/>
C. Mechanically altered diet – require change in texture of food or liquids (e.g., pureed food, thickened liquids)	<input type="checkbox"/>	<input type="checkbox"/>
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>
Z. None of the above	<input type="checkbox"/>	<input type="checkbox"/>

Section N	Medications
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N0420. High-Risk Drug Classes: Use and Indication		
1. Is taking Check if the resident is taking any medications in the following drug classes by pharmacological classification, not how it is used 2. Indication noted If Column 1 is checked, check if there is an indication noted for all medications in the drug class	1. Is taking	2. Indication noted
	Check all that apply ↓	Check all that apply ↓
A. Antipsychotic	<input type="checkbox"/>	<input type="checkbox"/>
B. Antianxiety	<input type="checkbox"/>	<input type="checkbox"/>
C. Antidepressant	<input type="checkbox"/>	<input type="checkbox"/>
D. Hypnotic	<input type="checkbox"/>	<input type="checkbox"/>
E. Anticoagulant	<input type="checkbox"/>	<input type="checkbox"/>
F. Antibiotic	<input type="checkbox"/>	<input type="checkbox"/>
G. Diuretic	<input type="checkbox"/>	<input type="checkbox"/>
H. Opioid	<input type="checkbox"/>	<input type="checkbox"/>
I. Antiplatelet	<input type="checkbox"/>	<input type="checkbox"/>
J. Hypoglycemic (including insulin)	<input type="checkbox"/>	<input type="checkbox"/>

Section O	Special Treatments, Procedures, and Programs
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O0110. Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that were performed at discharge	At Discharge Check all that apply ↓
Cancer Treatments	
A1. Chemotherapy	<input type="checkbox"/>
A2. IV	<input type="checkbox"/>
A3. Oral	<input type="checkbox"/>
A10. Other	<input type="checkbox"/>
B1. Radiation	<input type="checkbox"/>
Respiratory Therapies	
C1. Oxygen Therapy	<input type="checkbox"/>
C2. Continuous	<input type="checkbox"/>
C3. Intermittent	<input type="checkbox"/>
C4. High-concentration	<input type="checkbox"/>
D1. Suctioning	<input type="checkbox"/>
D2. Scheduled	<input type="checkbox"/>
D3. As Needed	<input type="checkbox"/>
E1. Tracheostomy care	<input type="checkbox"/>
F1. Invasive Mechanical Ventilator (ventilator or respirator)	<input type="checkbox"/>
G1. Non-Invasive Mechanical Ventilator	<input type="checkbox"/>
G2. BiPAP	<input type="checkbox"/>
G3. CPAP	<input type="checkbox"/>
Other	
H1. IV Medications	<input type="checkbox"/>
H2. Vasoactive medications	<input type="checkbox"/>
H3. Antibiotics	<input type="checkbox"/>
H4. Anticoagulation	<input type="checkbox"/>
H10. Other	<input type="checkbox"/>
I1. Transfusions	<input type="checkbox"/>

O0110. Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that were performed at discharge	At Discharge Check all that apply ↓
J1. Dialysis	<input type="checkbox"/>
J2. Hemodialysis	<input type="checkbox"/>
J3. Peritoneal dialysis	<input type="checkbox"/>
O1. IV Access	<input type="checkbox"/>
O2. Peripheral	<input type="checkbox"/>
O3. Midline	<input type="checkbox"/>
O4. Central (e.g., PICC, tunneled, port)	<input type="checkbox"/>
None of the Above	
Z1. None of the above	<input type="checkbox"/>

UNPLANNED DISCHARGE (End of SNF Stay)

A0310G =2

Section A

Identification Information

A2105. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
02. **Nursing home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
99. **Not Listed**

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider?

Enter Code

0. **No** – Current reconciled medication list not provided to the subsequent provider
1. **Yes** – Current reconciled medication list provided to the subsequent provider

A2122. Provision of Current Reconciled Medication List to Resident at Discharge

At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver?

Enter Code

0. **No** – Current reconciled medication list not provided to the resident, family and/or caregiver
1. **Yes** – Current reconciled medication list provided to the resident, family and/or caregiver

A2123. Route of Current Reconciled Medication List Transmission

Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider and/or resident/family/caregiver.

Route of Transmission	1. To subsequent provider	2. To resident/family/ caregiver
	↓ Check all that apply ↓	
A. Electronic Health Record	<input type="checkbox"/>	<input type="checkbox"/>
B. Health Information Exchange Organization	<input type="checkbox"/>	<input type="checkbox"/>
C. Verbal (e.g., in-person, telephone, video conferencing)	<input type="checkbox"/>	<input type="checkbox"/>
D. Paper-based (e.g., fax, copies, printouts)	<input type="checkbox"/>	<input type="checkbox"/>
E. Other Methods (e.g., texting, email, CDs)	<input type="checkbox"/>	<input type="checkbox"/>

Section C Cognitive Patterns

C1310. Signs and Symptoms of Delirium (from CAM©)

Code **after** evaluating cognitive status and reviewing medical record.

A. Acute Onset Mental Status Change

Enter Code <input type="checkbox"/>	Is there evidence of an acute change in mental status from the resident’s baseline? 0. No 1. Yes	
Coding: 0. Behavior not present 1. Behavior continuously present, does not fluctuate 2. Behavior present, fluctuates (comes and goes, changes in severity)	↓ Enter Code in Boxes	
	<input type="checkbox"/>	B. Inattention – Did the resident have difficulty focusing attention, for example being easily distractible or having difficulty keeping track of what was being said?
	<input type="checkbox"/>	C. Disorganized thinking – Was the resident’s thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
	<input type="checkbox"/>	D. Altered level of consciousness – Did the resident have altered level of consciousness as indicated by any of the following criteria? <ul style="list-style-type: none"> • vigilant – startled easily to any sound or touch • lethargic – repeatedly dozed off when being asked questions, but responded to voice or touch • stuporous – very difficult to arouse and keep aroused for the interview • comatose – could not be aroused

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Section K	Swallowing/Nutritional Status
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K0520. Nutritional Approaches		
While a Resident Performed <i>while a resident</i> of this facility and within the <i>last 7 days</i> At Discharge	1. While a Resident	2. At Discharge
	↓ Check all that apply ↓	
A. Parenteral/IV feeding	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeding tube (e.g., nasogastric or abdominal [PEG])	<input type="checkbox"/>	<input type="checkbox"/>
C. Mechanically altered diet – require change in texture of food or liquids (e.g., pureed food, thickened liquids)	<input type="checkbox"/>	<input type="checkbox"/>
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>
Z. None of the above	<input type="checkbox"/>	<input type="checkbox"/>

Section N	Medications
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N0420. High-Risk Drug Classes: Use and Indication		
1. Is taking Check if the resident is taking any medications in the following drug classes by pharmacological classification, not how it is used 2. Indication noted If Column 1 is checked, check if there is an indication noted for all medications in the drug class	1. Is taking	2. Indication noted
	Check all that apply ↓	Check all that apply ↓
A. Antipsychotic	<input type="checkbox"/>	<input type="checkbox"/>
B. Antianxiety	<input type="checkbox"/>	<input type="checkbox"/>
C. Antidepressant	<input type="checkbox"/>	<input type="checkbox"/>
D. Hypnotic	<input type="checkbox"/>	<input type="checkbox"/>
E. Anticoagulant	<input type="checkbox"/>	<input type="checkbox"/>
F. Antibiotic	<input type="checkbox"/>	<input type="checkbox"/>
G. Diuretic	<input type="checkbox"/>	<input type="checkbox"/>
H. Opioid	<input type="checkbox"/>	<input type="checkbox"/>
I. Antiplatelet	<input type="checkbox"/>	<input type="checkbox"/>
J. Hypoglycemic (including insulin)	<input type="checkbox"/>	<input type="checkbox"/>

Section O	Special Treatments, Procedures, and Programs
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O0110. Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that were performed at discharge	At Discharge Check all that apply ↓
Cancer Treatments	
A1. Chemotherapy	<input type="checkbox"/>
A2. IV	<input type="checkbox"/>
A3. Oral	<input type="checkbox"/>
A10. Other	<input type="checkbox"/>
B1. Radiation	<input type="checkbox"/>
Respiratory Therapies	
C1. Oxygen Therapy	<input type="checkbox"/>
C2. Continuous	<input type="checkbox"/>
C3. Intermittent	<input type="checkbox"/>
C4. High-concentration	<input type="checkbox"/>
D1. Suctioning	<input type="checkbox"/>
D2. Scheduled	<input type="checkbox"/>
D3. As Needed	<input type="checkbox"/>
E1. Tracheostomy care	<input type="checkbox"/>
F1. Invasive Mechanical Ventilator (ventilator or respirator)	<input type="checkbox"/>
G1. Non-Invasive Mechanical Ventilator	<input type="checkbox"/>
G2. BiPAP	<input type="checkbox"/>
G3. CPAP	<input type="checkbox"/>
Other	
H1. IV Medications	<input type="checkbox"/>
H2. Vasoactive medications	<input type="checkbox"/>
H3. Antibiotics	<input type="checkbox"/>
H4. Anticoagulation	<input type="checkbox"/>
H10. Other	<input type="checkbox"/>
I1. Transfusions	<input type="checkbox"/>

O0110. Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that were performed at discharge	At Discharge Check all that apply ↓
J1. Dialysis	<input type="checkbox"/>
J2. Hemodialysis	<input type="checkbox"/>
J3. Peritoneal dialysis	<input type="checkbox"/>
O1. IV Access	<input type="checkbox"/>
O2. Peripheral	<input type="checkbox"/>
O3. Midline	<input type="checkbox"/>
O4. Central (e.g., PICC, tunneled, port)	<input type="checkbox"/>
None of the Above	
Z1. None of the above	<input type="checkbox"/>